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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Text  Description automatically generated | Developmental Disabilities Administration (DDA)  Residential Health Center (RHC)  **Respite, Stabilization, and RHC Support Referral** | | | | | | | | | | | | | |
| **Client Information** | | | | | | | | | | | | | | |
| Client Name | | | | ADSA ID | | | | | Date of Birth | | Age | | Referral Date | |
| Parent / Legal Representative’s Name | | | | Emergency Phone (with area code) | | | | | | | DCYF Dependent?  Yes  No | | | |
| Client’s Address | | | | | | | | | Client Phone (with area code) | | | | | |
| Preferred Language | | | | | | | | | Interpreter Required  Yes  No | | | Translated Documents  Yes  No | | |
| Form completed by: | | Title | | | | | | | Phone (with area code) | | | | | Region |
| Client’s Current Program  Waiver  RCL  CFC only  NPS  State Only | | Recent Hospitalizations (previous 12 months): | | | | | | | | | | | | |
| Date | | Reason | | | | | | | | | | |
| Date | | Reason | | | | | | | | | | |
| Date | | Reason | | | | | | | | | | |
| **Settings** | | | | | | | | | | | | | | |
| **Current Setting** | | | | | | | | | | | | | | |
| Community Hospital:  In Home:  Adult Family Home (AFH):  Community Residential:  Correctional Facility: | | | | | | Unhoused  Foster Home  Mental Health Residential Treatment Facility:  State Hospital:  Other: | | | | | | | | |
| Contact’s Name at current setting Phone (with area code) Email | | | | | | | | | | | | | | |
| **Requested Setting / Service(s)** (Check all that apply) | | | | | | | | | | | | | | |
| [Enhanced Respite Services (ERS)](https://www.dshs.wa.gov/sites/default/files/DDA/dda/documents/policy/policy4.03.pdf)  [Intensive Habilitative Services (IHS)](https://www.dshs.wa.gov/sites/default/files/DDA/dda/documents/policy/policy4.07.pdf)  [Stabilization, Assessment, and Intervention Facility (SAIF)](https://www.dshs.wa.gov/sites/default/files/DDA/dda/documents/policy/policy4.25.pdf)  Crisis Bed-based Diversion  [Overnight Planned Respite Services (OPRS)](https://www.dshs.wa.gov/sites/default/files/DDA/dda/documents/policy/policy4.15.pdf) | | | | | | | [Planned Respite by a Nursing Facility at an RHC](https://www.dshs.wa.gov/sites/default/files/DDA/dda/documents/policy/policy17.01.02.pdf)  [Intermediate Care Facility (ICF) at an RHC](https://www.dshs.wa.gov/sites/default/files/DDA/dda/documents/policy/policy17.01.02.pdf)  [Nursing Facility (NF) at an RHC](https://www.dshs.wa.gov/sites/default/files/DDA/dda/documents/policy/policy17.01.02.pdf)  [Crisis Stabilization at Yakima Valley School](https://www.dshs.wa.gov/sites/default/files/DDA/dda/documents/policy/policy17.01.02.pdf)  [Emergency Transitional Support at Rainier RHC](https://www.dshs.wa.gov/sites/default/files/DDA/dda/documents/policy/policy17.01.02.pdf) | | | | | | | |
| Preferred / Requested Location, if applicable: | | | | | | | | | | | | | | |
| **Social Summary** | | | | | | | | | | | | | | |
| Include reason for request, family profile, and DDA services or other benefits accessed in the last 12 months. | | | | | | | | | | | | | | |
| Include key information about the individual such as preferred activities, likes / dislikes, strengths, abilities: preferred recreational activities and community participation | | | | | | | | | | | | | | |
| Any relevant school or employment information | | | | | | | | | | | | | | |
| Any cultural or religious support requirements? If yes, please describe. | | | | | | | | | | | | | | |
| Date(s) requested for OPRS or RHC planned respite:  From  to  From  to  From  to  Note: Verify requested dates are available prior to requesting OPRS ([see calendar(s)](https://stateofwa.sharepoint.com/sites/DSHS-DDA-REDP-OPRCA)). | | | | | | | | | | | | | | |
| **Behavior Support Needs** | | | | | | | | | | | | | | |
| Please check any behaviors below the provider should be aware of OR  **Check here if none** . | | | | | | | | | | | | | | |
| Biting  Eating Disorder  Elopement  Inappropriate toileting:  Fire setting  Head banging  Inappropriate sexual behaviors  Loud vocalizations | | | Physical aggression  PICA  Property destruction:  Self-injurious behaviors:  Substance use:  Sensory / noise / touch:  Suicidal attempts / threats: | | | | | | | Throwing objects  Verbal Aggression  Wandering / not exit-seeking  None  Other: | | | | |
| Restrictions in place at current residence (door / window alarms, food restrictions, other). If so, please describe. | | | | | | | | | | | | | | |
| What are things to avoid (loud music, touch, food, etc.)? | | | | | | | | | | | | | | |
| Most concerning behavior displayed at home, in the community, and their employment site or at school: | | | | | | | | | | | | | | |
| Is a behavior support plan being utilized at home or school?  Yes  No If yes, please provide a copy of the plan. | | | | | | | | | | | | | | |
| **Medical Needs** | | | | | | | | | | | | | | |
| Allergies (type):  Reaction:  Anemia / Blood Disorder  Blood Thinners  Catheters / Ostomies  Cancer (type):  Diabetes:  Insulin Dependent  Non-insulin Dependent  Dietary restrictions:  Dietary texture/ dysphagia:  Frequent falls  Gastrointestinal issues: | | | Internal Implants:  Multi-drug resistant organism (current or history)  Pressure or Wound Injury(s) (specify):  Respiratory disease:  Asthma  Frequent lung infection  Pneumonia  Recurrent aspiration  Ventilator  BiPap / C-Pap / Nebulizer | | | | | | | Seizures (if checked, please include type, frequency, severity):  Surgical Procedure; reason:  Tracheostomy  Chronic cough  Other  Tuberculosis / PPD history  Tube or other enteral feeding  Other: | | | | |
| Last Medical Appointment:  Provider Name:  Date:  Reason: | | | | | Last Psychoactive Medical Review:  Provider Name:  Date:  Reason: | | | | | | | | | |
| Medication Assistance Needed  Describe what type of assistance is needed to take medications and/or apply mediated ointments or drops (including vitamins):  Supervision  Verbal prompts  Hand in cup  Crushed in food  Physical assistance  Medications administered via g-tube or other enteral pathway  Individual does not have any oral / topical medications  Other:  Is nurse delegation needed?  Yes  No  Are there any current, unresolved medical issues?  Yes  No Describe: | | | | | | | | | | | | | | |
| What safety issues are of concern to you?    **Please note that respite providers may nee to request written instructions from the treating professional on the use of protective equipment such as helmets, arm splints, etc.** | | | | | | | | | | | | | | |
| Describe accessibility support needs and adaptive equipment required (ramp, wheelchair / ramp, roll-in shower, shower chair, Hoyer lift, or dietary related equipment): | | | | | | | | | | | | | | |
| **Supervision and Routine** | | | | | | | | | | | | | | |
| Supervision Requirements  Describe the level of supervision for health and safety (line of sight, one to one, awake staff, etc.): | | | | | | | | | | | | | | |
| Community Supervision Needs (1 to 1 in community due to challenges, can be supervised with other adults or children): | | | | | | | | | | | | | | |
| Describe typical daily routine  Morning routine: | | | | | | | | | | | | | | |
| Evening routine and bedtime: | | | | | | | | | | | | | | |
| Typical school / workday routine, if applicable: | | | | | | | | | | | | | | |
| Non-school / workday routine: | | | | | | | | | | | | | | |
| Describe nighttime support needs: | | | | | | | | | | | | | | |
| **Habilitative Goals and Desired Outcomes (complete for IHS and SAIF requests)** | | | | | | | | | | | | | | |
| Work with individual and family, legal representative, or primary support person to determine their goals. Review with identified regional specialists for the applicable program to determine that the goals are habilitative in nature, can be achieved in 90 days, and do not require medical treatment. | | | | | | | | | | | | | | |
| **Examples: Goals** | | | | | **Examples: Desired outcomes** | | | | | | | | | |
| 1. John will identify coping skills when interacting with his roommate. | | | | | John will reduce frequency and severity of physically aggressive behavior towards his roommate. | | | | | | | | | |
| 1. Sarah will learn how to develop skills necessary to setting and awaking to an alarm clock. | | | | | Sarah will set an alarm each night and awake in the morning with verbal cues. | | | | | | | | | |
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| **Discharge Plan** | | | | | | | | | | | | | | |
| What is the planned discharge setting?  Client will return to their previous setting with family / previous supports.  Client will seek new setting to move to upon completion of service;  Client has identified a new setting they will move to upon completion of service.  Client requesting nursing facility at an RHC, discharge not applicable.  Describe plan for discharge, including what needs to be in place to support a successful move and how the receiving support (family or provider) will participate in a successful transition out of the stabilization or respite setting. | | | | | | | | | | | | | | |
| **Post-Discharge Survey (required only for ERS, SAIF, and IHS** | | | | | | | | | | | | | | |
| Please indicate preferred method to receive the post discharge survey:  Via Email  Via Paper  Email or mailing address: | | | | | | | | | | | | | | |
| **Referral Checklist (include all that apply)** | | | | | | | | | | | | | | |
| Current DDA Assessment Details and Services Summary  Consent (DSHS 14-012)  Cross Systems Crisis Plan  Guardianship / Supported Decision-Making documentation  Applicable medical records, including current MAR Individualized Intensive Support Plan or Negotiated Care Plan  CRM Confirmed requested program(s) eligibility | | | | | Verify discharge plan and participant support (family agreement form, mutual acceptance confirmation, etc.)  Incident reports in the last 12 months  Functional Assessment / Positive Behavior Support Plan  SOTP Risk Assessment (if applicable)  Individualized Education Plan (IEP)  SER documenting clients requested service and information shared about the scope and support provided within requested service(s)  Other (please specify): | | | | | | | | | |
| **Application Review and Signatures** | | | | | | | | | | | | | | |
| Signature of Person Completing this form Date | | | | | | | | Printed name of person completing this form | | | | | | |
| Signature of Legal Representative Date | | | | | | | | Printed name of Legal Representative, if different | | | | | | |